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AUTHOR Candlin, C.; Lucas, J.
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ABSTRACT

A study investigates the roles and frames of reference of a family planning counselor as she offers information and counsel to her client and examines the implications for the training of counselors. First, the ideology of family planning counseling is discussed, focusing on the counselor's need to find an appropriate place on the counseling continuum between (1) intervention and (2) preservation of freedom of choice. The roles of counselor and client are then examined in this context. Areas of concern in the counselor-client interaction and procedures for interpreting them are outlined. The counselor's efforts to negotiate place on the counseling continuum are analyzed, using excerpts of an interview in which the relationship of smoking and contraception is the topic. Specific advising strategies are noted. It is proposed that the information gathered can be used to instruct counselors in strategies for shifting the counseling frame of reference along the continuum, through development of training models and instructional and assessment materials. A brief bibliography is included. (MSE)

5. Interpretations and explanations in discourse: modes of advising in family planning

C CANDLIN
University of Lancaster

and

J LUCAS
University of Hawaii at Manoa

The purpose of this study is to offer an account of the interaction between professional and client in the Family Planning Counselling interview. More specifically, it is to examine critically the roles and frames of reference of the counsellor as she seeks to offer information and counsel to her client. Central to this activity is the concept of 'advising', and the study seeks to elucidate what its modes are and how they are realised in terms of pragmatic principle, discourse structure and linguistic features.

Hale Ho'la Hou (House of New Life) was founded in 1975 in Kaumakapili Church out of concern for the lack of affordable medical care for the urban poor of Kalihi-Palama area. Three criteria guide its action: service must be provided 1) at low cost, 2) in a non-institutional setting, and 3) by a multilingual staff. The clinic is incorporated in the state of Hawaii as a non-profit corporation, and in 1983 it had 17 full-time employees, providing family planning, dental and nutritional services in addition to primary medical care. It seemed to us that the non-authoritarian relationship between professional and client within a context in which knowledge was being drawn on to offer information as well as education, might produce discourse which fluctuated along a continuum, the pole of which were information-giving and seeking on the one hand, and the specifying of contraindicated behaviour on the other. If this were so, then to be a counsellor was pragmatically and discoursally difficult, since neither the authoritarian nor the libertarian role would capture what counselling might turn out to be. This hunch was confirmed in discussions.

THE IDEOLOGY OF FAMILY PLANNING COUNSELLING

Why IDEOLOGY and its relevance to the analysis of discourse? We take the position that any analysis of language in use has to see such language as the skilled accomplishment of participants in the service of some social goal, and not merely in

terms of a text-as-object. Such an approach is interpretive, therefore, not merely descriptive, and implies an assessment by the analyst of the degree to which participants feel that they have achieved their particular goals. Nonetheless, such an interpretative account will remain inadequate if we cannot infer and explore the social conditions which imbue both particular performances and particular interpretations. To pursue this, any study will need to accommodate not only the distinct perceptions the participants have of the encounters in which they engage, but will also have to understand that discourse regularly naturalises participants values and beliefs in an unconscious manner. We take the view that participants use language, employ communication strategies and infer particular meanings without often any conscious awareness of how such usages act to portray personal, professional and sectional beliefs and values. Ideology in discourse reflects a view that talk maintains the reality of its participants through the taken-for-grantedness of its realisations and their value. The routines of conversation reinforce the routines and relationships of everyday life, and confirm participants in their roles, behaviours and beliefs. Language guides action, and commits participants to particular values and intentions. Ideology in discourse analysis begins from the point that it is crucial to display and explain how language can work indirectly, and under what conditions it can take effect. We start with the idea that the presence of an underlying ideology in talk is revealed at moments of communicative crux where participants' subjective realities are questioned, and turn it into a principled procedure. Ideology in this sense implies critique; i.e. it exposes values and beliefs, makes explicit role and function, and attempts to explore the degree of speaker's control over presuppositions and implicatures. In short, this approach seeks to demystify the hidden yardsticks against which meanings are constructed. It does so by subjecting the use of particular features of interactions to analysis and critique.

Contradictions within FPC are referrable to the relationship between FPC and factors in the social formation. These contradictions at the macro-level work down the line to particular textual choices at the micro-level. Although, in one sense, the purpose of FPC is straightforward, it is also highly value-laden - a socially significant educational and informational activity which is also subject to pressures of broader social policy. This conflict is one characteristic of social work in general, not merely in FPC. What makes FPC particularly problematic is that the issue of individual freedom vs. social responsibility is exacerbated by troublesome value dilemmas surrounding the public's and the counsellor's views about sex, in short, their ideologies. These views not only centre around what individuals regard as acceptable sexual behaviour, but also touch on their capacity to discuss such intimacies. Less often acknowledged, perhaps, is the

pressure upon workers in FPC to take account of current views on the social order, which directs FPC to the poor, the immigrant, the indigent and the medically high-risk. Notwithstanding the protection of the right of the client to decide, it would be naive to deny that certain groups experience the FPC event as coercive, and that certain FPC workers are engaged in debate on the need to prescribe for these high risk groups in any case. These issues point up the more general dilemma of social work in being an agent of change, yet allowing people the freedom to resist change.

There is, therefore, a continuum to be negotiated between intervention and the preservation of freedom of choice. It is this ideological dilemma which characterises the discourse of FPC, and highlights the ambivalence of frame of reference which we have noted. Our informants constantly stressed that their relationship was between professional and client, that clients were treated as individuals, that they were responsible for themselves, that counsellors were there to present facts and be non-judgmental. Nevertheless, being non-judgmental does not imply that FPC workers, or FPC in general, are without values. What we hope to show is that in the world of FPC 'facts' and 'information', like language, are not value-free.

ROLES OF COUNSELLOR AND CLIENT

It would be wrong to see the counsellor only as a provider of information. Some people (e.g. Deeds 1973), prefer to separate information from education, seeing the latter as going beyond the facts to developing sound family planning practices. In this view, communication with patient inevitably implies conscious intent to influence behaviour: 'counselling' which is aimed at providing the patient with emotional support and helping him adjust to his condition and reach his potential; and 'interviewing' which is designed to facilitate receiving the most pertinent information needed to make medical and educational diagnoses. The essential characteristic remains, the freedom of the client to accept or reject advice. Other people (e.g. Manisoff 1970), while separating information offering from counselling, elevate the protection of freedom of choice to a role equivalent to both these. Sometimes, however, a dilemma arises where the patient perceives the FPC as a person with authority and power to give or withhold financial assistance, and this perception conflicts with the other roles of the FPC. In practice, the dilemma of conflicting perceptions of FPC role between FPC and client, and the existence of external pressures from society, make it difficult for FPC to carry out its main roles: the giving and getting of information, provision of support and clarification of problems in an atmosphere of privacy, positiveness and lack of coercion. Deeds' distinction between information and education, for example is hard to make in practice, and so is the distinction between education and counselling. The

variation in perspective between client and FPC is one which stems from the counselling interview being not just an educational assessment, but a psycho-social one as well - there is a reason for the way that the education is being provided. In short, the lack of sharp distinction between roles in a FPC is a characteristic not easily separable from some territorial imprecision between the spheres of the 'educator', the 'social worker' and the 'counsellor'. There will always be some conflict in practice between a non-judgmental stance which advocates clients making their own decisions, and one which puts a requirement on the FPC to advocate in particular cases some form of birth control. At such moments, the FPC sustains a conflict between pressure to dispense, and the counsellor's general role of providing the options. It is the contention of this paper that the negotiation by the FPC of an appropriate place on the continuum, at different points within her encounter with her client, makes excessive demands on her powers of discourse, and that, conversely, it is through her discourse that these conflicts and this negotiation become apparent. From this follows the question of how far the particpants in this process, client and FPC, are aware of the significance of the transactions in which they are engaged, and how far they see them as a possible source of anomie and communicative breakdown. On the face of it, this is a much more subtle approach to the problems of FPC-client interaction than those our informants commonly identified: viz. insufficient language, lack of client feedback and the disturbing presence of partners.

OBJECTS OF FOCUS AND INTERPRETIVE PROCEDURES

The previous sections have provided a basis which allows us to identify some INTERPRETIVE PROCEDURES appropriate to the understanding of counselling discourse. The interpretive procedures we propose have the status of experimental hypotheses which need validation. The procedures themselves have a general cause in a conviction that discourse analysis and pragmatics needs to move beyond botanising to the making of more powerful generalisations about the interpretability of naturally-occurring talk. Such procedures may therefore have general relevance beyond FPC; they may offer us a way of comparing the value of utterances across activity types. The immediate cause for the procedures is the work of Labov and Fanshel (1977).

We argued above that the value of the counsellor's discourse can most appropriately be understood as fluctuating along a continuum between two poles. The two poles are (A) 'information-giving and seeking' and (B) 'specifying contra-indications'. At Pole A the counsellor exercises her role as educator, eliciting from the client information of a medical or demographic kind, assessing her knowledge of birth-control procedures, and then providing the appropriate information to fill in the gaps. At this pole, then,

the client is faced with making a decision or a choice, and is ideally given complete freedom of choice on the basis of this information. At Pole B, in contrast, the counsellor is concerned to detect and specify those behaviours and conditions of the client which may be medically contraindicated for the decision the client wishes to make. Given, however, that the medical staff have the authority to make prohibitive decisions - e.g. refusing to dispense the birth control pill to a heavy smoker - it becomes the responsibility of the counsellor to prepare the client for such decisions.

These two poles capture only part of the interaction between the counsellor and client in FPC, however. The question now arises of what transpires between the two poles? As the counsellor moves between the poles how does her role change, and how are these changes reflected pragmatically and discoursally? We suggest that as the counsellor moves along the continuum from Pole A in the direction of Pole B, her discourse takes on the characteristics of ADVICE. In making this assertion, we are of course aware that we may be in conflict with the accepted ideology of FPC outlined earlier.

Consider one example from our data. Client JA has come to the clinic for a refill of birth control pills. From her medical chart, the counsellor sees that not only is JA a heavy smoker, she is also 29 years old, has a family history of diabetes and cancer, and her blood pressure reading has come out slightly above normal - all contraindications of the use of the pill. In such a case, information such as:

> CR: '...smoking, what it does is it changes your circulation and it might be more chance, especially as you get older of strokes...'

would be considered as being offered within the 'counselling' frame, and may have been intended by the counsellor as advice either to cut down on smoking or to consider another form of birth control. The client, however, who wants both the pill and to continue smoking, prefers to hear the information as 'education'. What constitutes advice, then, is both complex to determine and discoursally difficult to perform unequivocally. It would seem to involve the following factors in the context of FPC:

1: the counsellor attempts in principle to avoid overt advice, but in the case of contraindicated behaviour must give advice in some form, since she is not empowered to direct;

2: the client expects to receive advice from the counsellor but may or may not want to accept such advice in a given case.

As the counsellor negotiates her place on the continuum between Poles A and B, fluctuating from frame to frame, the client interprets her utterances depending on the frame she perceives the counsellor to be operating in. On the basis of this argument, we propose below a set of interpretive procedures for both counsellor and client relating in particular to the concept of advice in FPC.

1: If the information given by the counsellor is directly related to a decision to be made by the client, and to her benefit, such information will be perceived by the client as advice.

2: If information which is medically contraindicative is given by the counsellor in response to a behaviour or a request of the client, such information will be perceived by the client to be either advice or prohibition and will constitute a denial of the request.

3: If the counsellor experiences the need to offer advice, she will do so covertly, formulating it as information.

4: If the client rejects such covert advice, the counsellor must employ other modes of advising.

MODES OF ADVISING AND MODES OF CONTROL

In this section we will consider modes of advising in the light of the authority possessed by the counsellor, both as she perceives it, and as it is perceived by her clients. The issue, then, is the negotiation of place on the counselling continuum as the counsellor goes about the process of advising within the boundaries of her authority. Much of the authority of the counsellor arises by virtue of her knowledge and experience in FPC. Within HHH it is the counsellor, a trained social worker, who has expertise in FPC matters. Her authority has certain limits, however, in that she cannot make medically-related decisions. Such decisions must be referred to the Physician's Assistant. In her relationship with her clients, the counsellor in our study stresses that she makes special efforts to de-emphasise her authority, and in fact claims to see the concept of authority as detrimental in the establishing and maintaining of an atmosphere conducive to free and open talk between herself and her clients: '...the only way you can have any kind of a good relationship in counselling...is for the patient to feel she can trust you...and if you come across as if you're really on a totally different level from what they are, it'll be really difficult for them to open up and let you know what their fears are or what questions they have'.

Nonetheless, the role of the counsellor within her institutional context, and the recourse made to her by her clients, inevitably

accord her that ascribed authority. Perceptions of its intensity will of course vary from client to client, depending on the client's background, her experience and her pre-conceived notions of what a family planning counsellor is like, all in relation to the purposes of the client's visit. A young woman faced with a difficult decision, for example, may perceive the counsellor as a caring figure, whereas the client simply intending to obtain birth-control supplies may perceive her as a provider of a service or as a gatekeeper.

Our counsellor, then, has at least two constraints on her authority:

1. she lacks the authority to make medically-related decisions, and

2. her awareness of the client's possible perception of her as an authority constrains her to minimize the authority she does have in order to maintain a relationship of trust and solidarity with her client.

It is our contention that these constraints act to influence the discourse of both counsellor and client, especially the former, towards greater indirectness of utterance.

An obvious area of application of pragmatics to an understanding of the counsellor's role is that of speech act theory. In stressing the centrality of the concepts of 'benefit to hearer' and 'the hearer's best interest' to the act of advising, we have already drawn informally on the work of Searle (1969, 1975). We have, however, been at pains to indicate that this concept of 'advising', at least as it applies to FPC, is not something that can be identified unerringly, either by the analyst, or by the counsellor, for whom such indeterminacy of performative value is of ideological significance. Our data support the contention that this indeterminacy is intentional; necessarily so, we might argue, if the counsellor is to accommodate the second of the constraints we identified above.

Like Leech (1977) we believe that acts are best placed on continua, instead of being seen as discrete and unproblematically identifiable phenomena. Leech proposes that three pragmatic scales place some bounds on these continuous phenomena: the COST-BENEFIT SCALE specifies how much the act referred to in the propositional content of the speech act is judged to cost or benefit the speaker or the hearer; the OPTIONALITY SCALE specifies to what degree the performance of the content of this speech act is at the choice of the speaker or hearer; the third scale, POLITENESS, is a function of the first two scales, such that politeness factors increase as optionality and cost-benefit factors increase. Another model for

TABLE ONE

Extracts from the data

CR ...the reason I'm asking I'm asking you these questions is because sometimes the birth control method you choose can affect your body in different ways and let's say circulation for the pill or hormonal for the pill...which if it's family related...you could be more of a likely candidate for that problem...so we like to know what your family history is...we like to be aware of that too

...

...it looks like the left side is OK and like I said...the bottom...this is not to alarm you it's just to make you aware...if it's ninety or above there might be some contraindication to the use of the pill or if next time you come back...and it's like ten millimetres we'll want to discuss that since you're using the pill...

...

OK, the other thing that I see from your chart is that you do smoke cigarettes... do you know about that and how it affects...how it's affected with the use of the pill

JA Yes I do

CR can you tell me what you know

JA huh

CR can you tell me what you know

JA about smoking and taking the pill

CR uh huh

JA mm...the risk of getting cancer is higher

CR ok...the risk of cancer with the pill might just be from a hormonal level like if you had cancer in your family, breast cancer for instance, but smoking, what it does is, it changes your circulation and it might be more chance, especially as you get older of strokes

JA oh ...

CR uh huh, so that's and you smoke quite a bit and you're 29, so you're in a high risk group so she's definitely gonna talk to you about that today...um...it's up to the physician's assistant if the birth control method is dispensed or not, if it's a prescribed method...Have you ever thought about discontinuing smoking?

JA uh, I thought about it (laughs)

CR Do you think you'd be able to do it?

JA I don't know (laughs) I guess if I really wanted to...I've been smoking for a long time

CR are you under more stress now

JA I guess you could say so...yeah, cause it was last year that I started smoking more

CR do you think that if you worked on those things you might be able to cut down

JA on the stress you mean
CR well...I don't know what the stress is and I don't know if you're open to talking about that but...from your facial expressions...it seems that you're really hesitant to make a decision to discontinue smoke I mean smoking...that's gonna have to be something up to you... Do you think that if the stress was eliminated that maybe...
JA I could cut down
CR or quit...for your age it's probably better for you to just quit altogether
...
CR that's not necessarily a decision you have to make right this minute. I know that (the physician's assistant) will be taking to you about that...and what we can do is maybe talk about some alternate birth control methods in case she really feels strongly that it wouldn't be healthy for you to continue using the pill...um...the IUD might be an appropriate method for you to use since you've had two children...two full term pregnancies...
...
I know this is kind of backtracking...um...as far as the cigarettes go...if you feel like you need help with that...there's the American cancer society...they have programs to help you with that...
JA to quit smoking
CR yeah...if you need a support group or if it gets down to that...and you're going to choose that over the pill or vice versa...or if you felt like whatever stress...you're having is out of control and you don't have insurance at your job...we don't offer that kind of counselling here...all our work is short term but there is a local mental health clinic
JA mm mm
CR according to where you live...from what I'm getting from you...seem to be reasonably a...everthing's ok unless I'm not picking up...well...you know it's not easy cause everybody... well I've got my bad habits too...and it's not easy...I smoked for eight years too so I know it's not easy
JA did you quit
CR yeah I got allergic to the smoke...so that made it easier I think...if there's some reason sometimes that you know it's not good for you... I mean...I knew that I could feel the allergy, the bumps on my tongue...for you it's the same way, it's a little bit different you can't maybe see what's going on with the pill when you're smoking...but if you know from your knowledge has increased now...that might make it easier for you to make a decision about it.

handling politeness and its realisation in text is to be found in Brown and Levinson (1978). They propose a dimension of POWER and a dimension of SOLIDARITY. Power refers to the mutual recognition by both participants that one is in a position of superiority over another, while solidarity refers to the strength of the mutual bond of intimacy between the participants. A third dimension they offer is that of IMPOSITION, i.e. the degree of burden placed or implied by the utterance of one participant on the other. These axes interact in discourse, and from these interactions the degree of indirectness of the utterance emerges, and consequent upon that, the estimation of its degree of politness.

FPC consultations provide relevant examples of all these factors, and their interplay affects the quantity and nature of indirectness and the types of politness strategies used by the counsellor. Consider again the case of JA discussed earlier. The counsellor, CR, does not have the authority to deny JA the pills, but she sees her role as preparing JA for the possible subsequent refusal of the pill by the medical staff. Whether or not the pills are eventually refused, CR believes that smoking and the use of the pill are potentially dangerous to the client. She sees either a change to an alternative form of birth control or abandoning smoking as preferable courses of action to their concurrent use. The client, on the other hand, sees both changing birth control method and quitting smoking as being costly to her. The pill is more convenient than other methods, and smoking is pleasurable and a difficult habit to break. In cost-benefit terms, then, CR perceives a high benefit in JA's changing methods or quitting smoking, whereas JA sees both alternatives as very costly. The degree of optionality, from CR's point of view, depends on how likely she believes it to be that the Physician's Assistant will refuse to dispense the pill. In power terms, CR lacks the power to refuse the pill, and in any case, avoids the exercise of overt authority, preferring a relationship of solidarity in which social distance between her and her client is minimized.

How then does CR exercise the face-threatening act (FTA) of advising her client that she should quit smoking or change her method of birth control? The data in Table One demonstrate a variety of strategies, all of which constitute, in our view, attempts by CR to lead the client towards the realisation that the long term cost of not accepting her advice might well outweigh the more immediate costs. CR employs a range of strategies: overall she uses negative politeness where she performs an FTA with regard to JA's want not to be impinged on, positive politeness when she performs an FTA with regard to JA's wants, or by going off record and doing the FTA indirectly. What follows is a list of those particular strategies employed by CR. Although it appears from the data to be significant that the strategies are employed in a particular order, and that the first strategy will typically take

precedence in encounters of this type, it is likely that other orders of strategy use are both possible and likely. The variables influencing this order would include topic, client type, nature of client's business, quality of client's responses to the counsellor on the topic at issue. What we propose here then, is at best an invitation to further study. (In the examples below, A1 refers to the issue of giving up smoking, A2 to a change in contraceptive method.)

STRATEGY 1: Provide relevant information
STRATEGY 2: Ascertain client's awareness of this information
STRATEGY 3: Shift responsibility for FTA to higher authority
STRATEGY 4: Focus on A1, but indirectly
STRATEGY 5: Abandon A1, focus on A2 then resume focus on A1
STRATEGY 6: Claim common ground, empathise
STRATEGY 7: Place responsibility on JA
STRATEGY 8: Allocate disproportionate consultation time to A1 & A2

Soon after the beginning of the consultation, CR employs strategy 1. She explains how the client's family history of both cancer and heart disease could make her a candidate for similar problems if she takes the pill. She explains how JA's slightly abnormal blood pressure reading might contraindicate the use of the pill. In so far as this information is already known to the client, we have an instance of a violation of Grice's (1967) maxim of quantity. Even the giving of this information is mitigated, however (ln 1-18). Immediately following this, CR refers to JA's smoking habit. Here, rather than explaining on-the-record the dangers of smoking and the pill CR attempts to determine via strategy 2 how much JA already knows about the attendant risks. She then fills in the appropriate information (ln 16-36). Strategy 3 involves CR telling JA that the physician's assistant will be talking to her about her problem. In this way CR escapes the need to accept responsibility for the FTA by placing it on the higher authority (ln 35-38). Following this, CR begins a line of questioning focusing on the possibility of JA quitting smoking, her reasons for smoking, and possible alternative solutions to this 'problem'. Once again, however, CR's questions are heavily mitigated (ln 38-63). With this, CR provides JA with a pamphlet on smoking and the pill, and then leaves the topic of smoking, steering the focus towards the topic of alternative methods of birth control. In doing so she effectively approaches smoking again, but by an indirect route. When JA mentions that she has heard about the IUD method, CR takes the opportunity not only to explain the method, but to suggest its particular appropriateness for JA (ln 65-66). After explaining the other available methods, CR appears to be moving toward ending the consultation by explaining the examination which is to follow, the hours of the clinic etc. But before closing the consultation she hedges and using strategy 5 returns to the topic of smoking (ln 68-80). The consultation continues, and CR makes use of strategy 6,

claiming common ground as an example of positive politness, sharing her own experience with smoking and how she was able to quit (ln 83-93). CR's final strategy is one which returns to the characteristic open-endedness of counselling. Strategy 7 places responsibility for the decision on the client. CR reminds JA that now she is informed of the dangers it is for the client to decide what is best for herself. CR also mitigates again here. Nevertheless, the references to unseen processes, the possibility of exploring further alternatives and the suggestion that non-clinic doctors might prescribe where the clinic would not seem in our view to shift CR towards advising. We suggest as a final strategy 8 one which strictly speaking is not linked to any particular point within the consultation. We refer to the proportion of consultation time devoted to the twin topics of smoking and the pill. More than two thirds of the total talking time was used in this way, which indicates its significance to CR, especially in view of CR's complaint that insufficient time was available for client counselling.

In this discussion, we have illustrated how throughout this consultation the counsellor employs strategies which quite typically shift within the counselling frame along this advising continuum. Characteristic is CR's indirectness, evidenced by much mitigation and redressive action. However, it is not the purpose of this paper merely to present a set of theoretical results. We also believe that data of this sort can be exploited for applied purposes. In our view, Applied Linguistics has a major contribution to make to a range of educational and training programmes concerned with human service professions. We see two areas in which this study might be applied, and these are illustrated in Table Two.

1. Training Model
Here we envisage the development of a range of prototypical models for INSET courses for FP counsellors. Because these models will need to take a wide range of variables into account, they are probably best built up from a series of modules (cf Candlin et al 1981). These modules fall into two main types: Training Purposes and Case Studies. So, for example, a WORKSHOP ON FPC COMMUNICATION SKILLS might be organised along the lines shown in Table Two.

2. Media Packages
Here we envisage support materials for the training models. Models for such packages already exist (cf Candlin et al 1978). Typically such packages contain a mix of audio-visual media and printed text, and would be available in both teacher-assisted and self-study modes. They would focus on the sorts of areas outlined in Table One, and an important part of their design would be their authenticity, particularly in the types of interaction they would be designed to promote. They might also include evaluative measures designed to assess counsellor skills, especially as these relate to

and make use of the concepts of pragmatics and discourse explored in this study.

TABLE TWO

Two types of training models, and how they might be integrated into a workshop for counsellors

1: Training Purposes:
Three types of module are envisaged:
..Recognition exercises to heighten pragmatic awareness;
..Experiential exercises designed to involve counsellors in a range participatory techniques;
..Counselling Exercises designed to allow Counsellors to formulate a mode of response to a range of actual FPC events.

2: Case Studies.
Here we envisage a variety of case studies focussing on significant variables in the FPC process, viz: client type, visit type, purpose type and situation type.

3: FPC Communication Skills: A Workshop for Counsellors.

1	Problem Recognition (sub groups)	(video input)
2	Ethnographic/Pragmatic/ Linguistic Categories (plenary)	(text+discussion input)
3	Application of 2 to new data (subgroups)	(analysis of FPC data)
4	Generalisations about pragmatics of FPC (sub-groups)	(inferences from FPC data)
5	Comparison of Analyses (plenary)	(sub-group hypotheses vs. report hypotheses)
6	Case-studies (individual/pair/trio)	(personal reactions to case studies)
7	Good FPC Guide (sub-groups)	(design of an FPC manual)
8	Comparison of Guides (plenary)	(Guides from sub-groups plus this report)

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